



MAGISTRATES COURT *of* TASMANIA

CORONIAL DIVISION

Record of Investigation into Death (Without Inquest)

*Coroners Act 1995
Coroners Rules 2006
Rule 11*

I, Robert Webster, Coroner, having investigated the death of Fiona Searle

Find, pursuant to Section 28(1) of the Coroners Act 1995, that

- a) The identity of the deceased is Fiona Searle;
- b) Ms Searle died as a result of injuries sustained after she fell from a pathway while she was seated in her electric wheelchair;
- c) Ms Searle's cause of death was traumatic closed head injuries; and
- d) Ms Searle died on 8 May 2021 at Hobart, Tasmania.

Introduction

In making the above findings I have had regard to the evidence gained in the comprehensive investigation into Ms Searle's death. The evidence includes:

- The Police Report of Death to the Coroner (PROD);
- Royal Hobart Hospital (RHH) Death Report to Coroner;
- Affidavits as to identity and life extinct;
- Postmortem report of the forensic pathologist Dr Donald Ritchey;
- Medical records obtained from the Tasmanian Health Service (THS);
- Medical records obtained from Independent Health Care Services (IHCS);
- Medical Records obtained from Lenah Valley Medical Centre;
- Records with respect to Angus Searle Snr (Father of Ms Searle);
- Records obtained from the Tasmanian Electoral Commission;
- WorkSafe Tasmania investigation report together with affidavits, diagrams, plans, photographs and supporting materials;
- Records from Ambulance Tasmania (AT);

- Reports with respect to Ms Searle's wheelchair from Aidacare Healthcare Equipment together with the wheelchair's service history (Clive Poulton) and from Sunrise Medical (Mark Greig);
- Affidavit of Reginald Searle;
- Affidavit of Debra Hayes;
- Affidavit of Leanne Berry;
- Affidavit of Tegan Pinnow;
- Affidavit of Emma Jackson;
- Affidavit of Barbara Gillies;
- Affidavit of Constable Ian Bellette;
- Affidavit of Constable Heidi Woodhead;
- Affidavit of Constable Nicholas Monk;
- Affidavit of First Class Constable Dean Walker; and
- Photographs and forensic evidence.

This investigation concerns an accident which occurred on the grounds of the Glenorchy Primary School on 1 May 2021. On that day the State election in Tasmania was being held and the gymnasium at the school was being used as a polling booth. The school is bordered by Hull Street, Kensington Street, Main Road and Continental Road. Ms Searle lived in a unit in Kensington Street and needed to cross to the other side of the school's grounds in order to cast her vote in the gymnasium. An aerial photograph showing the layout of the area is as follows:



Figure 1: Aerial photo of the school and its surrounds.

The gymnasium is the red roofed building just above the notation on Figure 1 which says, “Glenorchy Primary School Carpark”.

To reach the gymnasium from Kensington Street Ms Searle had to manoeuvre her wheelchair up a concrete ramp and past a sunken sitting area in the school’s grounds. This area is depicted in the following photographs:



Figure 2: Concrete ramp leading to sunken sitting area.



Figure 3: Area at the top of the concrete ramp with the sunken sitting area depicted to the right of the photograph.

As Ms Searle has negotiated the area at the top of the ramp her wheelchair has gone over the edge depicted by the green line in Figure 3 and has ended up on top of her in the sunken seated area below. That area is depicted in the following photographs:



Figure 4: The sunken sitting area depicted from the top of the concrete ramp.



Figure 5: The top of the concrete ramp depicted from the sunken sitting area.

Background

Ms Searle was born on 6 November 1969 and died at the age of 51 years.¹ At the time of her death, Ms Searle was single, and she resided in a unit at Kensington Street in Glenorchy.² Ms Searle suffered from a range of medical conditions, which required her to use a wheelchair.³

Ms Searle was born to Maureen Jordan and Angus Searle (Snr). Ms Searle was the youngest of seven siblings however her mother left the family when Ms Searle was between two and three years old. This was because Angus Searle (Snr) was a heavy drinker and Ms Jordan was the victim of family violence. She attempted to retrieve her children some 12-18 months later however she was prevented from doing so by Mr Searle and his new partner. Subsequently Mr Searle was convicted and sentenced to a period of imprisonment for a crime and in his comments on passing sentence Underwood CJ noted Ms Searle's father struggled with bringing up his family on social security benefits.⁴ Ms Jordan, when speaking to the investigating officer, advised her older children helped raise her younger children and their upbringing would have been terrible.⁵

Health

Prior to her death, Ms Searle was in poor health and suffered from a range of medical conditions. Primarily, Ms Searle was diagnosed with spina bifida⁶ and congenital hydrocephalus⁷ conditions she had endured since birth.⁸ Her spina bifida required Ms Searle to use a wheelchair. The congenital hydrocephalus was treated with a ventriculoatrial shunt, which Dr Alexandra Roberts, Ms Searle's general practitioner, says has controlled that condition. This device diverts the buildup of fluid on the brain.⁹

Ms Searle had undergone a nephrectomy in 1994, which left her with one functioning kidney. She previously had an ileal conduit (IC), which caused her to suffer recurring urinary tract infections. This is a procedure where the urinary tract is reconstructed and the ileum is used

¹ See Exhibit C1-PROD at page 1.

² See Exhibit C1-PROD at page 1.

³ See Exhibit C9- Affidavit of Reginald Searle, Exhibit C10-affidavit of Debra Hayes and the various medical records listed on page 1.

⁴ Exhibit C25-Comments on passing sentence of Underwood CJ dated 13 June 2006.

⁵ Exhibit C27- Notes of Senior Constable Barnes.

⁶ Spina bifida is a type of neural tube defect where a baby's spine and spinal cord do not develop properly during the first month of pregnancy.

⁷ Hydrocephalus is the buildup of fluid in cavities called ventricles deep within the brain. The excess fluid increases the size of the ventricles and puts pressure on the brain. Too much pressure can damage brain tissues and cause a range of symptoms related to brain function.

⁸ See Exhibit C23- The records from the Lenah Valley Medical Centre and exhibit C10-affidavit of Debra Hayes.

⁹ See Exhibit C23- The records from the Lenah Valley Medical Centre.

as an alternative pathway for urine to exit the body after a person has their bladder removed. The IC does not store urine. It is a way to remove urine from the body. Dr Roberts says Ms Searle would often be admitted to hospital due to these infections. Her remaining kidney was diagnosed as a polycystic kidney in 2019, requiring a JJ Stent to be inserted.¹⁰ Subsequently, Ms Searle experienced complications relating to the stent.

Ms Searle was overweight, she had type 2 diabetes, osteoarthritis, hypercholesterolaemia, hypertension, she wore a colostomy bag and suffered from chronic pain.¹¹ Her hospital records also disclose admissions for treatment of foot ulcers which are related to her diabetes.¹²

Ms Searle also suffered from mental health issues throughout her life. She was diagnosed with depression during her childhood and subsequently developed post-traumatic stress disorder. In late 2013, she was placed on a continuing care order by doctors for one month.¹³ The power to make a continuing care order was provided by s26 of the *Mental Health Act 1996*. The order could be made where a doctor considered the criteria for a patient's involuntary admission and detention in an approved hospital were met. Ms Searle was previously diagnosed with borderline personality disorder and she had expressed suicidal ideation.¹⁴ Leading up to the order being made, Ms Searle was admitted to the Department of Psychiatry at the RHH, with decreased mood.¹⁵ She had attempted suicide on a number of occasions with some instances highlighted as follows. On 21 February 2015, Ms Searle attempted suicide by overdosing on paracetamol.¹⁶ On 20 September 2014 she attempted suicide by overdosing on her regular medication.¹⁷ It is reported when Ms Searle was seen at the RHH she said she had taken the medication to 'end it all'.¹⁸ There had been no suicide attempts since 21 February 2015 and no further expression of suicidal ideation.

Ms Searle lived independently since she was 19 years old with assistance on a daily basis. Ms Searle's brother, Reginald Searle, and her sister-in-law, Debra Hayes, would also help Ms Searle in particular with cooking, mowing the lawn and other household chores.¹⁹ Ms Searle received assistance from carers from Independent Health Care Service (IHCS)²⁰ from 2015 and she transitioned to the National Disability Insurance Scheme in August 2018.²¹ Carers

¹⁰ See Exhibit C23- The records from the Lenah Valley Medical Centre.

¹¹ See Exhibit C23- The records from the Lenah Valley Medical Centre.

¹² Exhibit C6- The THS Records.

¹³ Exhibit C6- The THS Records-Part 1 pages 5-8.

¹⁴ Exhibit C6- The THS Records-Part 1 pages 5-8.

¹⁵ Exhibit C6- The THS Records-Part 1 pages 5-8.

¹⁶ Exhibit C6- The THS Records-Part 3 pages 717-719.

¹⁷ Exhibit C6- The THS Records-Part 2 pages 3-7.

¹⁸ Exhibit C6- The THS Records-Part 2 page 5.

¹⁹ Exhibit C10- Affidavit of Debra Hayes.

²⁰ IHCS provides a range of in-home services to support the aged and people living with a disability.

²¹ Exhibit C19- Records of Independent Health Care at page 2.

would assist daily with personal hygiene, domestic duties and cleaning. Ms Searle did however attempt to maintain her independence as much as possible and she was independent with local community access. She managed her own medications including insulin, bill management, appointments and up until very shortly before her death she also attended to her own personal shopping. She received support for her fortnightly grocery shopping.²² She moved around using a motorised wheelchair and her brother, Reginald, says Ms Searle was proficient in the use of her wheelchair, and that the wheelchair was “her legs”.²³

About a year before her death, Mr Searle says he was advised by his sister’s doctors during one of her hospital admissions that she was deteriorating and she would need palliative care for her conditions.²⁴

Ms Searle was admitted to hospital on 22 April 2020 for urosepsis, among other things, with doctors noting that the JJ stent, referred to above, had migrated and that there were multi-resistant organisms (that is she had an infection caused by bacteria which were resistant to treatment by medications).²⁵ It was planned that she would be referred to community palliative care following her discharge on 22 May 2020.²⁶ Previous hospital admissions also noted taking a more palliative approach to treating her conditions.²⁷ By 13 August 2020 however, Ms Searle requested that palliative care physicians no longer be involved in her care as her condition had stabilised.²⁸ She was not receiving palliative care in the community at the date of her death.

On 16 April 2021, Ms Searle was admitted to hospital for a recurring urinary tract infection, as well as chronic back pain, a possible seizure and a sacral wound. Ms Searle was subsequently discharged after receiving 12 days of antibiotics for the infection and treatment for her other conditions. The RHH records suggest Ms Searle may have experienced a seizure, but a review by neurologists led to the conclusion she was less likely to have suffered a seizure.²⁹

Circumstances of Death

On 1 May 2021, Ms Searle attended Glenorchy Primary School to vote on election day. The Glenorchy Primary School was one of 70 school premises that were used to host voting on

²² Exhibit C19- Records of Independent Health Care at page 2.

²³ Exhibit C9- Affidavit of Reginald Searle.

²⁴ Exhibit C9- Affidavit of Reginald Searle.

²⁵ Exhibit C6- The THS Records-Part 4 pages 279-287.

²⁶ Exhibit C6- The THS Records-Part 4 pages 279-287.

²⁷ Exhibit C6- The THS Records-Part 3 pages 190-192.

²⁸ Exhibit C6- The THS Records-Part 1 page 449.

²⁹ Exhibit C6- The THS Records-Part 5 pages 120-124.

that day.³⁰ Voting was conducted at the school gymnasium which is located at the Hull Street entrance to the school.³¹

The location of the gymnasium meant that people entering to vote from Kensington Street pass through the school grounds via a concrete ramp that passed by a sunken sitting area which led to the administration office of the school. At the commencement of the ramp, at ground level, it is 1380mm wide and the width of the ramp between the hand rails is 1160mm. It is 16 m long. At the top of the ramp adjacent to the steps leading into the sunken sitting area, the width of the ramp from the hand rail on the right hand side as you travel up the ramp and the edge of the ramp on the left hand side is 1255mm (see Figure 5). At the time of Ms Searle's death, there were no guard rails around the edge of the upper level of the sunken sitting area-see Figures 3, 4 and 5.³²

The sunken sitting area is a three-sided courtyard area that faces Kensington Street (see Figure 3). The sitting area is made up of two steps, with the first step being 490mm off the ground. The height between the first step and the upper level surface (second step) is 400mm. The height from the top of the ramp to the ground is 890mm. Green paint marks the edge of the sunken sitting area on the top step at the top of the ramp as well as on the second step or seat (see Figures 3 and 4.) A set of five stairs which lead into the sunken sitting area is located at the top of the ramp (see Figure 5).³³ The top edge of the sunken sitting area is "pretty much in line" with the handrail on the left hand side of the ramp as one travels up the ramp.³⁴

At approximately 10:50am, AT received a call from Emma Jackson³⁵ that Ms Searle had been found in the sunken sitting area of the school after it was believed she had fallen off the top of the ramp with her wheelchair into the sunken sitting area.³⁶ Fortunately one of her carers, Tegan Pinnow, had voted at the school and was leaving when she came across the scene. She was able to advise AT of Ms Searle's health deficits.³⁷ Ms Searle's fall was witnessed by Barbara Gillies, who was leaving the school after she had voted. She says she did not see Ms Searle commence to fall and nor was she able to determine what had caused the wheelchair to fall. Ms Gillies observed Ms Searle hitting her head in the sitting area as she fell. She was face down and her wheelchair then bounced off the second step before

³⁰ Exhibit C8-WorkSafe Tasmania investigation report together with affidavits, diagrams, plans, photographs and supporting materials-Tab 8-letter Department of Education to Tasmanian Electoral Commission dated 12 April 2021.

³¹ Exhibit C11- Affidavit of Leanne Berry.

³² Exhibit C16- Affidavit of Constable Woodhead.

³³ Exhibit C16- Affidavit of Constable Woodhead.

³⁴ Email from Constable Woodhead.

³⁵ Exhibit C13- Affidavit of Emma Jackson.

³⁶ Exhibit C7- Records from AT.

³⁷ Exhibit C12- Affidavit of Tegan Pinnow.

hitting Ms Searle in the back of the head. Despite this Ms Searle was restrained in her wheelchair by a seatbelt which had to be unclipped before the wheelchair could be separated from Ms Searle. This whole process took a number of minutes.³⁸

Ms Pinnow says members of the public quickly came to Ms Searle's aid. She was pinned underneath her wheelchair, which was removed by those who came to her assistance. Ms Pinnow says Ms Searle was coming in and out of consciousness, was unable to talk and that Ms Searle did not recognise her. When Ms Searle regained consciousness, she cried out in pain.³⁹

Ms Gillies, who is a retired programme manager of an adult disability service, spoke to Ms Pinnow who had identified herself as one of Ms Searle's carers. Ms Gillies advised her, once she became aware Ms Searle lived close by, to get from Ms Searle's home her treatment plan in order to assist the officers from AT. Ms Pinnow left the scene to attend to that task. While Ms Pinnow was absent Ms Gillies observed Ms Searle suffer some seizures.⁴⁰

By 11:04am paramedics were assisting Ms Searle. Ms Searle was not orientated to time and place, had no recollection of the accident, had no obvious trauma to her head and denied headache, visual changes, nausea and there was no vomiting. By 11:30am Ms Searle had been extricated from the sunken sitting area and she was at the RHH by 12:00pm.⁴¹

After being treated in the Emergency Department Ms Searle was admitted to the General Medical Ward of the RHH at 1:51pm. Her Glasgow Coma Scale⁴² (GCS) score was 12, with *"dilated and sluggish pupils bilaterally"*. Ms Searle underwent a CT scan which revealed multiple *"intraparenchymal haemorrhages involving both cerebral hemispheres"* but noted areas of bleed not consistent with head trauma. An NG tube was inserted due to Ms Searle's reduced conscious state and antibiotics were provided for a possible urinary tract infection given her medical history.

Over subsequent days, Ms Searle's condition deteriorated. She continued to experience seizures, even when provided with anti-seizure medication. Her condition did not improve despite treatment. By 4 May 2021, Ms Searle's GCS had fallen to 3.⁴³ Due to Ms Searle poor prognosis and her rapid deterioration, and after discussions with her family, the decision was

³⁸ Exhibit C14- Affidavit of Barbara Gillies.

³⁹ Exhibit C12- Affidavit of Tegan Pinnow.

⁴⁰ Exhibit C14- Affidavit of Barbara Gillies.

⁴¹ Exhibit C7- Records from AT.

⁴² The Glasgow Coma Scale (GCS) is used to objectively describe the extent of impaired consciousness in all types of acute medical and trauma patients. The scale assesses patients according to three aspects of responsiveness: eye-opening, motor, and verbal responses and a score from 1 to 5 is given for each of the 3 aspects which results in a score of between 3 to 15 on the scale.

⁴³ Exhibit C6- The THS Records-Part 5 page 81.

made to place Ms Searle in palliative care. Ms Searle subsequently died in the morning of 8 May 2021.⁴⁴

Investigation

A postmortem was conducted by the forensic pathologist Dr Ritchey who concluded that Ms Searle died from traumatic head injuries she suffered when she fell.⁴⁵ No toxicological sample was taken as Ms Searle had received medical treatment at the RHH for the 7 days prior to her death. I accept Dr Ritchey's opinion.

There is conflicting evidence regarding the direction Ms Searle was travelling in and what caused her to fall. As Ms Searle fell, Ms Gillies observed Ms Searle was facing Kensington Street as was the wheelchair.⁴⁶ This suggests Ms Searle was heading home after voting. Subsequent inquiries with AT were not able to confirm the direction Ms Searle was facing when officers arrived however I note she had been removed from her wheel chair by that time. However, it was suggested to the investigating officer by AT that one ambulance officer believed Ms Searle was facing towards Kensington Street when they arrived. Despite Ms Gillies' assertion that Ms Searle was facing towards Kensington Street when she fell, evidence from the Tasmanian Electoral Commission establishes Ms Searle did not vote on the day of the election.⁴⁷ If Ms Searle was on her way to vote, she would not have been facing towards Kensington Street when she fell as that street is in the opposite direction of the gymnasium. It is possible that Ms Searle turned as she fell or that she was moved when bystanders helped lift the wheelchair off her. In addition photographs taken by Constable Woodhead⁴⁸ depict scuff marks and gouges on the edge of the seating in the sunken sitting area, on the edge of the concrete within the sunken sitting area but at the very top near the ramp and on the concrete wall of the ramp within the sunken sitting area but near to the top. Photographs taken by First Class Constable Dean Walker⁴⁹ depict scraping to the underside of the power box which forms the base of the wheelchair, scraping to the side of the left front wheel, scraping to bolts on the left side of the wheelchair, green paint on the upright brace to the left rear of the seat, scraping to the rear left wheel bracing of the wheelchair, bending to the rear left seat brace and scraping and damage to the front left side of the seat. This damage suggests that the left side of the wheelchair came into contact with the areas photographed by Constable Woodhead. For this to occur I find the bottom of the wheelchair has scraped the top of the ramp as it has gone over the edge at which point the

⁴⁴ Exhibit C6- The THS Records-Part 5 pages 27-29 and Exhibit C2- RHH Death Report to Coroner.

⁴⁵ Exhibit C5- Postmortem report of the forensic pathologist Dr Donald Ritchey.

⁴⁶ Exhibit C14- Affidavit of Barbara Gillies.

⁴⁷ Exhibit C20- Records obtained from the Tasmanian Electoral Commission.

⁴⁸ Exhibit C16- Affidavit of Constable Woodhead.

⁴⁹ Exhibit C18- Affidavit of First-Class Constable Dean Walker.

left side of the wheelchair has dropped and collided with the areas of the sunken sitting area photographed by Constable Woodhead. This physical evidence and the fact Ms Searle had not yet voted suggests to me Ms Gillies is mistaken about Ms Searle's direction of travel and she was in fact heading towards the gymnasium to vote at the time she fell. I so find. Ms Gillies went on to say, although she did not see what caused Ms Searle to fall or the start of the fall, she believed Ms Searle had a seizure and hit the controls and the wheelchair has spun around in the opposite direction of travel so she ended facing towards Kensington Street. For the reasons which follow below I do not think Ms Searle suffered from a seizure. That said it really makes no difference which direction Ms Searle was travelling in. What is clear is that her wheelchair left the ramp and fell into the sunken sitting area where she sustained injuries that caused her death.

Ms Searle was prescribed a number of medications at the time of her death. Among them were pregabalin, quetiapine, stemetil, physeptone and hydromorphone hydrochloride. All of those drugs can cause drowsiness, dizziness, sedation and falls. However a review of Ms Searle's records obtained from her general practitioner in the 18 months leading up to her death reveal the most common symptom she complained about was pain followed by nausea. She also had problems sleeping. This suggests her medication was not likely the cause of her losing control of her wheelchair.

Ms Gillies says in her opinion Ms Searle suffered a seizure which caused her to lose control of her wheelchair before she fell.⁵⁰ While this is possible her general practitioner says Ms Searle did not have a history of seizures and to her knowledge, Ms Searle had never been treated for such a problem. Dr Roberts explained that the combination of medications could have lowered Ms Searle's threshold for seizures however as mentioned there was no history of seizures and Dr Roberts was not aware of Ms Searle being treated for seizures.⁵¹ The only evidence of a seizure is recorded in the third full paragraph on page 7. However on review the treating doctors did not think Ms Searle had suffered a seizure.⁵² The evidence therefore does not support a finding that Ms Searle had a seizure shortly prior to her death. Although Ms Gillies reports that Ms Searle had two seizures after the accident this is more likely due to the effect of the head injuries on her pre-accident impaired brain structure and function.

A possible cause of the fall is whether Ms Searle's wheelchair may have malfunctioned or whether she lost control. Ms Searle used a QM710 Controller wheelchair, which is a motorised wheelchair that can travel at a maximum speed of 10km/h. The wheelchair is

⁵⁰ Exhibit C14-Affidavit of Barbara Gillies.

⁵¹ Exhibit C23-The records from the Lenah Valley Medical Centre.

⁵² Exhibit C6-The THS Records-Part 5 page 122.

operated by a joystick on the control panel by the user. Ms Searle was described as being an experienced wheelchair user.⁵³ A physical examination of the wheelchair was conducted by Mr Clive Poulton of Aidacare which is a business that provides health care equipment. He determined from his examination the wheelchair was both mechanically and operationally sound. Mr Poulton concluded the condition of wheelchair was in operational order and it was not the cause of the accident. Mr Poulton says there was nothing unusual with the control mechanism.⁵⁴ A review of the operating parameters and system fault logs of the software of the wheelchair, which was conducted by Mark Greig of Sunrise Medical, found that the operating parameters did not indicate any faults that would lead to a loss of control. Although a review of the wheelchair's fault logs identified some faults these were generated from normal safe use of the wheelchair and therefore Mr Greig concluded these faults would not have led to Ms Searle losing control of her wheelchair.⁵⁵

I therefore conclude Ms Searle did not lose control of her wheelchair due to a seizure or because of the effects of her prescribed medication or due to a malfunction of the wheelchair. It is likely she has miscalculated where she was on the ramp and when she has come off the ramp she has come too close to the edge. This has resulted in the accident. I also find the evidence does not support a hypothesis that Ms Searle committed suicide. There had not been an attempt for a number of years and there is nothing in the recent medical records which suggested Ms Searle was suicidal or even had any suicidal ideation. Although she was in poor health it was, for her, at the time of her death quite stable.

Following Ms Searle's death, a WorkSafe Tasmania investigation was conducted by Micheal Grant who was an inspector appointed under the *Work Health and Safety Act 2012*. The sunken sitting area and the ramp adjacent to it were part of building works conducted at the school in 2016. These works complied with the National Construction Code (NCC) and the Building Code of Australia (BCA).⁵⁶ Subsequently, a certificate of completion with respect to the building works was granted by the Glenorchy City Council (GCC) on 16 May 2018.⁵⁷ The "schedule of maintenance-prescribed essential building services" notes that access for people with a disability was to be "inspected every 3 months to ensure no changes and continuing compliance".⁵⁸ Green paint was used to mark the edges of the sunken sitting area, both on the first step and on the upper level.⁵⁹ The paint marking the edge of the area was

⁵³ Exhibit C9- Affidavit of Reginald Searle.

⁵⁴ Exhibit C21- Report of Mr Clive Poulton.

⁵⁵ Exhibit C21- Report of Mr Mark Greig.

⁵⁶ See Exhibit C8-WorkSafe Tasmania File at Tabs 1 and 9.

⁵⁷ See Exhibit C8-WorkSafe Tasmania File at Tab 9-Certificate of Completion.

⁵⁸ See Exhibit C8-WorkSafe Tasmania File at Tab 9- Schedule of Maintenance, table 1.12, dated 21 July 2017.

⁵⁹ See Exhibit C8-WorkSafe Tasmania File at Tab 10.

considered by Inspector Grant to be inadequate.⁶⁰ He does not say why this is so but perhaps the reason is the paint colour is the same colour as the floor of the sunken sitting area which has fake green grass covering it. Inspector Grant also noted that Tasmanian Electoral Commission employees conducted a general safety inspection when setting up. However, that inspection did not extend to an assessment of slip or falls risks.⁶¹

Following Ms Searle's fall, an inspection of the sunken area revealed two scuff markings on the concrete edge near to where the green paint had been applied. The first of the marks was found approximately 1530-1590mm, and the second 1770-1780mm, from the inside edge of the stairs to the scuff marks on the concrete seat.⁶² Corresponding green marks were found on Ms Searle's wheelchair.⁶³ Gouge marks were also found on the concrete edge. Ms Leanne Berry, the business manager of Glenorchy Primary School, was unable to confirm whether any of these markings were recent or old;⁶⁴ it is probable they were recent given the marks on the wheelchair.

Inspector Grant concluded the cause of the fall was because the edge of the sunken sitting area was unguarded. He considered this risk could have been controlled by marking the edges of the sunken area with yellow paint or rippled strips, such as the ones at the top or bottom of the ramp, on the edge of each drop to indicate a change in the levels of the concrete. He also recommended rails be placed across the top of the sunken sitting area which would prevent access to that area from the point at which it was entered by the wheelchair.⁶⁵

Following the accident, water filled temporary barriers were placed along the edge of the sunken sitting area where Ms Searle fell.⁶⁶ Inspector Grant, on or about 23 February 2023, issued an improvement notice pursuant to s191 of the *Work Health and Safety Act 2012* to the Department of Education Children and Young People which is responsible for the Glenorchy Primary School.⁶⁷ In correspondence between the Department of Education and Inspector Grant, dated 16 March 2023, the school advised⁶⁸ that in compliance with the improvement notice it had installed permanent bollards around the edge of the sunken sitting area, adjacent to the ramp but has left the other two sides of the sunken sitting area

⁶⁰ See Exhibit C8-WorkSafe Tasmania File at Tab 1 page 9.

⁶¹ See Exhibit C8-WorkSafe Tasmania File at Tab 1 page 9.

⁶² Exhibit C16- Affidavit of Constable Woodhead Monk.

⁶³ Exhibit C18- Affidavit of First-Class Constable Walker.

⁶⁴ Exhibit C11- Affidavit of Leanne Berry.

⁶⁵ See Exhibit C8-WorkSafe Tasmania File at Tab 1 page 11.

⁶⁶ See Exhibit C8-WorkSafe Tasmania File at Tab 1 page 11.

⁶⁷ See Exhibit C8-WorkSafe Tasmania File at Tab 15.

⁶⁸ See Exhibit C8-WorkSafe Tasmania File at Tab 15.

unguarded. The three sides of the sunken sitting area have been marked with yellow paint. The bollards are depicted in the following photograph:



Figure 6: Permanent bollards installed in compliance with the Improvement Notice.

I agree with the findings made by Inspector Grant. The absence of a barrier surrounding the edge of the sunken sitting area creates a risk of falls since there is no barrier immediately after the stairs at the top of the ramp.

While the bollards might prevent a wheelchair from going over the edge, they would not prevent young children at the school from overbalancing and falling onto the very hard surface below and as Figure 4 shows there is nothing to stop anyone or anything using the footpath on the other two sides of the sunken sitting area from falling. There is clearly a foreseeable risk of injury in these circumstances. It is not too difficult to envisage another wheelchair going off the unprotected sides or young school children, who are playing chasings in the playground and who are often unaware of such risks, falling from all three sides. This is despite a direction from the principal or someone else that such games are not permitted in this area.

Comments and Recommendations

I accept the alterations to the school including the ramp and sunken sitting area complied with the NCC and the BCA and they were approved by the GCC given the certificate of

completion which was issued in respect of the building works. However, compliance with those Codes did not prevent Ms Searle's accident. The installation of the bollards as depicted in Figure 6 may only prevent people using a wheelchair on the ramp from going over the edge but they will not prevent the other potential accidents mentioned in the last paragraph. I therefore **recommend** a fence, similar to that depicted in Figures 2 and 3, be erected around the three sides of the sunken sitting area. There should be a gate in the fence to provide access to the steps on each side of the area.

I extend my appreciation to investigating officer Senior Constable Alisha Barnes for her very thorough investigation and report.

The circumstances of Ms Fiona Searle's death are not such as to require me to make any further comments or recommendations pursuant to s28 of the *Coroners Act 1995*.

I convey my sincere condolences to the family and loved ones of Ms Searle.

Dated: 31 October 2024 at Hobart in the State of Tasmania.

Magistrate Robert Webster
Coroner